

EMPLOYEE: _____ DATE OF BIRTH: _____ HOME PHONE: _____

EMPLOYEE HEALTH PROGRAM
SURVEILLANCE FOR TUBERCULOSIS

1. What year did you first have a positive skin test? _____
2. Were you ever immunized against T. B. with BCG? [] Yes [] No
3. Did you have an active case of T. B.? [] Yes [] No
If so, where in your body? _____
4. Did you receive medications (INH, rifampin, streptomycin injections, etc.) for T. B.? [] Yes [] No
If so, when? _____
5. Did you have surgery for T. B.? [] Yes [] No If yes, when? _____
6. When and where was your last chest x-ray? _____
When and where did you last have your sputum checked? _____
Result? _____

RISK FACTORS:

1. Have you had exposure to a case of communicable pulmonary tuberculosis within the past two years? [] yes [] no If yes, when? _____
2. Have you had a negative tuberculin test within the past two years? [] Yes [] No
3. Do you have diabetes mellitus? [] Yes [] No
Severe? _____ Control? _____ [] Yes [] No
4. Do you have any severe immunologic deficiencies? [] Yes [] No
5. Are you on immunosuppressive therapy? [] Yes [] No
6. Do you have silicosis? [] Yes [] No
7. Have you had a gastrectomy? [] Yes [] No
8. Is your alcohol intake excessive? [] Yes [] No
9. Do you have a human immunodeficiency virus infection? [] Yes [] No
10. Do you now have any of the following symptoms?
 - a. Productive cough? [] Yes [] No
 - b. Night sweats? [] Yes [] No
 - c. Weight loss without trying? [] Yes [] No
 - d. Unexplained fevers? [] Yes [] No

INSTRUCTIONS TO MEMBER: See your physician if you develop a chronic productive cough, night sweats, weight loss without trying, or unexplained fevers.

Member signature: _____ Date: _____

Any risk factor present? [] Yes [] No
Any symptom present? [] Yes [] No

If yes:

- {1} Chest x-ray Date: _____
- {2} Reported to Public Health Nurse along with a copy of x-ray report. Date: _____
- {3} Referred to physician? [] Yes [] No
If yes, Name of Physician: _____ Date: _____

Evaluator: _____ Date: _____